UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FLOLAN (epoprostenol)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN A LETTER OF MEDICAL NECESSITY

CRITERIA:

- Covered only for patients with documented Primary Pulmonary Hypertension.
- If patient has a history of substance abuse, the patient must successfully complete a substance abuse rehabilitation program immediately before being placed on Flolan, or must have documented abstinence (urine or blood test) for a period of at least six months. (Repeat on authorization renewal.)

AUTHORIZATION:

6 Months

RE-AUTHORIZATION:

6 Months

- Up dated letter of medical necessity showing progress of patient.
- Repeat urine or blood test showing patient is not having problems with substance abuse.

8/9/6